STATE OF CALIFORNIA – Health and Human Services Agency | Department of Mental Health

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES QUARTERLY CLAIM FOR REIMBURSEMENT – ADMINISTRATIVE COST
MH1982 B (Revised 09/13/2011)

| Date | County Code | County |
|---|---|---|
| State Fiscal Year | Quarter (check one) ☐ July-Sept ☐ Oct-Dec ☐ Jan-Mar ☐ Apr-June | |

| | Total | Healthy Families Program | MCHIP | Other Medi-Cal Specialty Mental Health Program | Non-Reimbursable |
|---|---|---|---|---|---|
| 1. Direct Facility Treatment Expenditures | | | | | |
| 2. Maximum Administrative Percentage | | 10% | 15% | 15% | |
| 3. Maximum Administrative Claim (line 1 multiplied by line 2) | | | | | |
| 4. Actual Administrative Expenditures | | | | | |
| 5. Lower of line 3 or 4 | | | | | |
| 6. Administrative Federal Medical Assistance Percentage | | 65% | 50% | 50% | |
| 7. Administrative Federal Financial Participation (line 5 multiplied by line 6) | | | | | |

**I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Section 1090 et. sec. of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; that the claim is based on actual, total-funds expenditures for services to eligible beneficiaries; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with the law. The County further certifies under penalty of perjury that: all claims for services provided to county mental health clients have been provided to the clients by the County; the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department is accurate and complete. The County understands that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. Pursuant to Section 433.32 of Title 42, Code of Federal Regulations (CFR), the County agrees to keep for a minimum period of three years after the final determination of costs is made through the DMH reconciled Cost Report settlement process and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Care Services (DHCS), the Medi-Cal Fraud Unit, California Department of Mental Health (DMH), California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also certifies under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.**

Date: _____ Signature: _____
Local Mental Health Director

Executed at _____, California

**I CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts; , that I am authorized to sign this certification on behalf of the County, and that the information is to be used for filing a claim with the federal government for federal funds pursuant to Section 430.30 of Title 42, CFR. I understand that misrepresentation of any information provided herein constitutes a violation of state and federal law. I further certify under penalty of perjury that the claim is based on actual, total-funds expenditures made by the County of public funds that meet the requirements for claiming federal financial participation (FFP) pursuant to all applicable requirements of state and federal law, including, but not limited to, Sections 430.30 and 433.51 of Title 42, Code of Federal Regulations (CFR), and the Federal Office of Management and Budget (OMB) Circular A-87, and that the expenditures claimed have not previously been, nor will they be, claimed at any other time as claims to receive FFP funds under Medicaid or any other program. I understand that Department must deny any payment if it determines that the certification is not adequately supported for purposes of claiming FFP. I understand that all records of funds expended are subject to review and audit by DMH, DHCS and/or the federal government and that, pursuant to Section 443.32 of Title 42, CFR, all records necessary to fully disclose the extent of services furnished to clients must be kept for a minimum of three years after the final determination of costs is made through the DMH reconciled Cost Report settlement process and retained beyond the three year period if audit findings have not been resolved.**

Date: _____ Signature: _____

Title: _____ Executed at _____, California
(County Auditor-Controller, City Finance Officer, or Local Mental Health Accounting Officer)

Mail the signed claim form to Department of Health Care Services, MHP Cost Reporting and Rates Development, 1600 9th Street, Room 120, Sacramento, CA 95814 or scan and e-mail the signed claim to 1982BClaim@dhcs.ca.gov.

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# Instructions

**Heading Instructions**

Enter the date the claim form is submitted, the County Code, the name of the County, the fiscal year in which the administrative expenditures were incurred, and the quarter in which the administrative expenditures were incurred. Complete one claim form for each quarter. Round all figures to the nearest cents.

**Line Item Instructions:**

1. Enter the specialty mental health direct facility expenditures incurred during the quarter by the county for each program (Healthy Families, MCHIP, and other Medi-Cal Specialty Mental Health Program) based on the treatment claim costs for each program typically reported on claim form MH 1982A. Refer to the Mental Health Aid Code Master Chart on DMH's website for a definition of the Medi-Cal aid codes included in each program. MCHIP aid codes include 8N, 8R, 8P, and 8T. Direct facility expenditures include claims for county providers and contract providers reimbursed through the Medi-Cal Specialty Mental Health system and hospital inpatient providers reimbursed through the Department of Health Care Services' Medi-Cal Fiscal Intermediary.

2. The maximum allowed administrative percentage is shown for each program (no entry required).

3. Multiply line 1 by line 2 to compute the maximum administrative claim allowed for each program in this quarter.

4. Enter the actual administrative expenditures incurred during the quarter for each program. Counties should allocate total administrative expenditures between the programs consistent with the allocation approaches allowed for the cost report, which include (1) the relative percentage of program recipients in the population served by the county or (2) the gross costs of each program. Counties should apply the same approach consistently from quarter to quarter and on the year end cost report.

5. Enter the lower amount of line 3 or 4 for each program.

6. The relevant Federal Medical Assistance Percentage (FMAP) is shown for each program (no entry required).

7. Multiply line 5 by line 6 to compute the administrative Federal Financial Participation (FFP) for each program.

**Certifications**

Each claim form must include the signed certification of the Local Mental Health Director and either the County Auditor-Controller, City Finance Officer, or the Local Mental Health Accounting Officer.

**Submit signed claim form to:**

Department of Health Care Services
MHP Cost Reporting and Rates Development
1600 9th Street, Room 120
Sacramento, CA 95814
Email: 1982BClaim@dhcs.ca.gov